

Application for License to
Operate a Long-term Care Facility

*Mailed Validation
letter, 12/29/11*

For Office Use Only
Received 12.15.11
Amount \$840.

Ch #
03826

I. IDENTIFICATION

Name LP Prestonsburg, LLC
Address 147 North Highland Avenue
City/County/Zip Prestonsburg, Ky 41653-7748
Telephone number 606-886-23
Administrator Lynn Fletcher
Date facility operation began at current address _____
Date facility began operation under current owner November 1, 2007

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	_____	_____
Nursing Home	_____	_____
Nursing Facility	<u>56</u>	<u>56</u>
Intermediate Care	_____	_____
ICF/MR	_____	_____
Personal Care	_____	_____

II. CONTROL (check one in each column)

State
County
City
Private

Profit XXX
Nonprofit

Individual
Partnership
Corporation
LLC

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

N/A

(OVER)

RECEIVED

DEC 15 2011

OFFICE OF INSPECTOR GENERAL

12/31

If facility owned or leased by a corporation, complete the following:

Name of corporation LP Prestonsburg, LLC
12201 Bluegrass Pkwy Louisville, KY 40299
Address of corporation _____
President or Chairman N/A
Vice President N/A
Secretary N/A
Treasurer N/A

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent
Signature Healthcare, LLC
12201 Bluegrass Parkway
Louisville, KY 40299

Management Company
Signature Clinical Consulting Services, LLC
Signature Consulting Services LLC
12201 Bluegrass Parkway
Louisville, KY 40299

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.


Signature of authorized representative

Chief Financial Officer

Title

12/2/11
Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)